**PATIENT LIABILITY FORM**

**LIABILITY**The CAP Foundation assumes no, and hereby disclaims all, liability for the testing, diagnosis, or treatment of women participating in the See, Test & Treat program (see Rider 1). Participating sites should engage their Compliance and/or Risk Management Department to gain an understanding of and address any liability issues. It is expected that the care, testing, and treatment to be provided in the See, Test & Treat protocol by the participating gynecologists, cytologists, radiologists, pathologists, and mammography technologist shall be consistent with the standards of care applicable to such specialties.

CAP Foundation does not need a separate waiver of liability form signed by the patient. However, here is sample language that your team can use to develop your own liability waiver in conjunction with your compliance and/or risk management department:

**Waiver of Liability *(Sample Language for Sites*)**

I understand, acknowledge and agree to the following:

• I am voluntarily participating in the See, Test & Treat program taking place on INSERT DATE.

• I understand and agree that the screenings I am participating in treatment rendered are being conducted by volunteer physicians and other health care professionals/assistants in my best interest, for the benefit of my health, and are preliminary in nature only.

• I understand that the Sponsors and the participating volunteers make no claims or guarantees with respect to the accuracy of these screening evaluations due to the limited nature of the services provided.

• I agree that it is my responsibility to follow up on any recommendations or diagnoses that are made during these screenings, and obtain follow up treatment from my personal physician.

• I agree to indemnify and hold harmless the participating Sponsors and volunteers from any and all claims, liability and expenses (including attorney fees and other costs) arising out of advice given or not given, tests conducted or any other action or inaction on the part of the participating Sponsors or volunteers, before, during or after this health screening event.

• HIPAA Notice Acknowledgment: I have received or I have been provided the opportunity to receive a copy of the “Notice of Privacy Practices” that explains when, where and why my confidential health information may be used or shared. I acknowledge that the Sponsors, affiliated organizations and their staff may use and share my confidential health information with others in order to treat me or to arrange for payment of my bill, and for issues that concern the Sponsors operations and responsibilities.

By reading this waiver of liability; I understand the provisions and my waiver is made knowingly and voluntarily.

Name Date

Signature